ADVANCING THE CULTURE OF SAFETY:

Using Safety Behaviors to Prevent Errors

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Presenter

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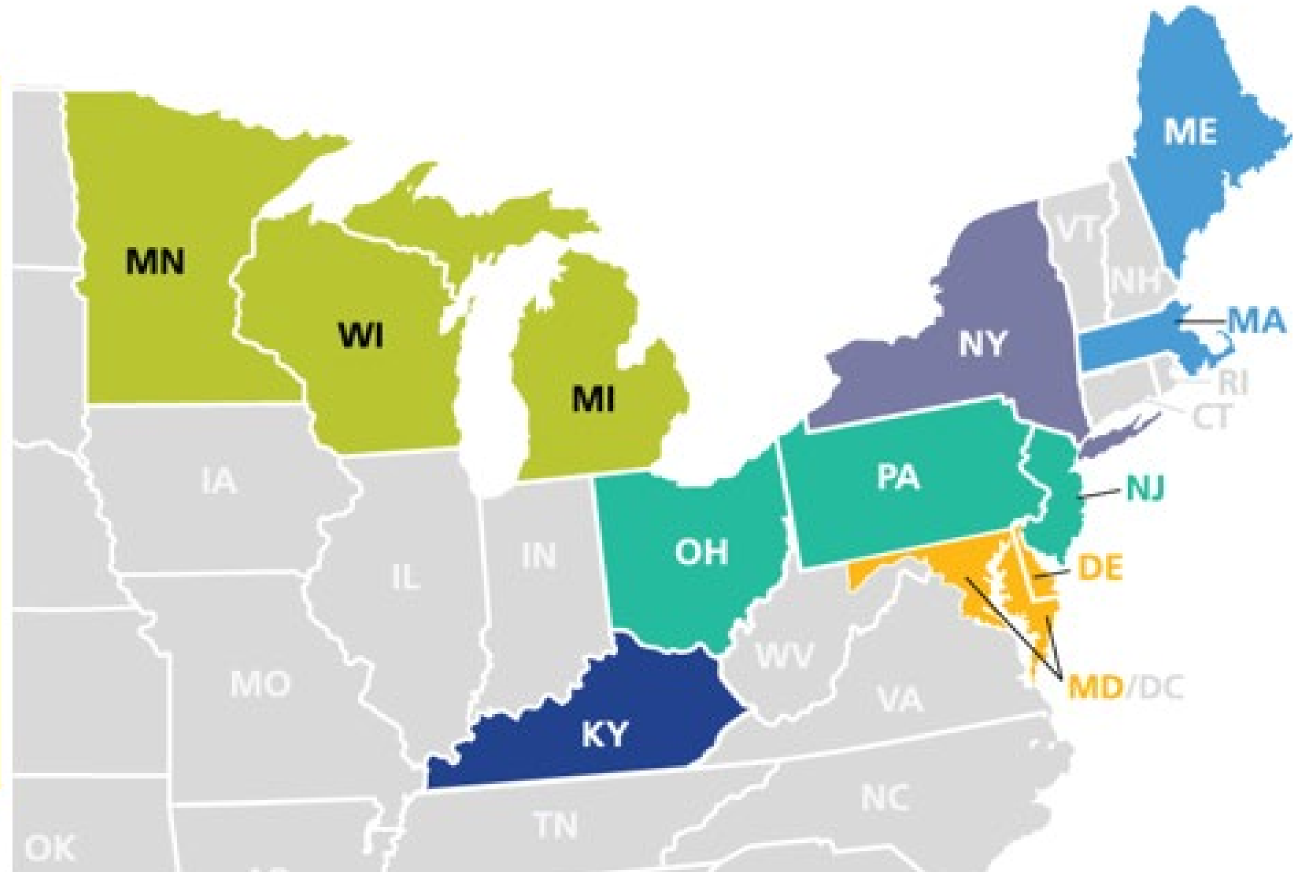
Patient Safety Subject Matter Expert for IPRO/HQIC

IPRO Hospital Quality Improvement Contractor (HQIC)

- IPRO supports hospitals in improving care delivery systems affecting vulnerable populations
- IPRO works with 272 hospitals across 12 states
- Focus areas include:
  - All-cause harm
  - Patient and family engagement
  - Health equity
  - Immunizations and vaccines
  - Healthcare-acquired infections



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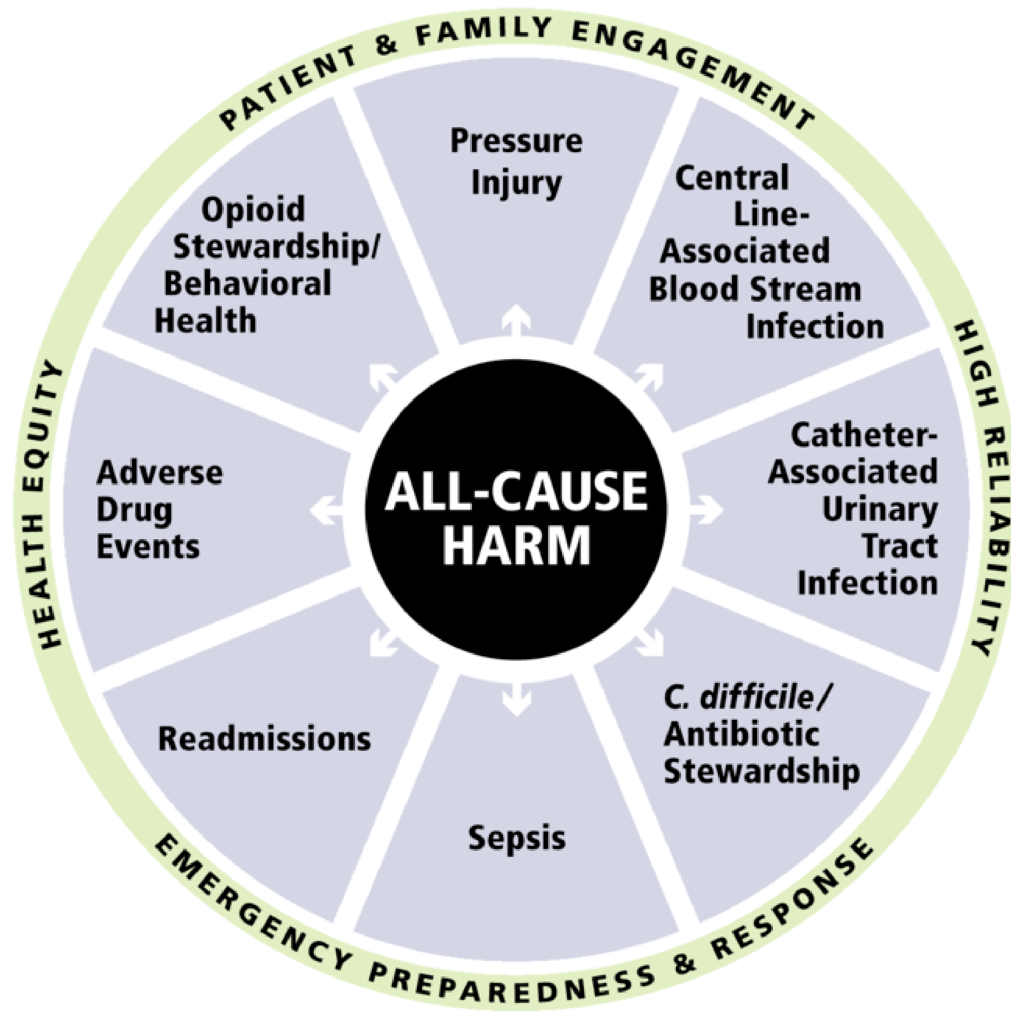
IPRO HQIC’s Circle of Safety: All-Cause Harm Prevention Model



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Objectives

- Understand how errors occur
- Learn approaches to safety behaviors associated with error prevention
- Excel in patient safety by reducing preventable harm
- Understand how to use S.T.A.R (Stop, Think, Act, Review) to prevent skill-based errors

Your Thoughts…..

In your career, have you made an error or almost made an error (near-miss)?

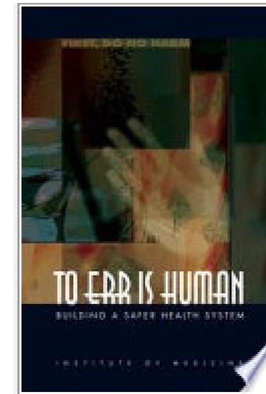
Harm in Healthcare – “A 747 a Day”

Why is attention to patient safety important?

IOM report: “*To Err is Human: Building a Safer Health System*” –

Experts estimate that as many as 98,000 people die in any given year from medical errors that occur in hospitals.

98,000/365 = 268 people/day



That would equal one plane crashing and killing everyone on board every day of the year!!!

Institute of Medicine (US) Committee on Quality of Health Care in America. To Err is Human: Building a Safer Health System. Kohn LT, Corrigan JM, Donaldson MS, editors. Washington (DC): National Academies Press (US); 2000. PMID: 25077248.

The Challenge: The Joint Commission Sentinel Event Data 2022 Annual Review

In 2022, there were 1,441 sentinel events reported

Top 10 Leading Reviewed Sentinel Event Types (CY2022)

Event Types	N	% of Total
Fall	611	42%
Delay in treatment	89	6%
Unintended retention of a foreign object	88	6%
Wrong surgery*	85	6%
Suicide	73	5%
Assault/rape/sexual assault/homicide	60	4%
Fire/burns	49	3%
Perinatal event	33	2%
Self-harm	30	2%
Medication management	30	2%

[Sentinel Event Data CY2023 Annual Summary (jointcommission.org)](#)

Patient's Perspective

Don't Harm Me

Heal Me

We can hear this voice each and every time we care for our patients, that will define the exceptional patient experience that we all want and need to provide.

Errors and Harm in Healthcare

- Medical errors cause thousands of deaths every year in the United States. According to the *Journal of Patient Safety*, medical errors contribute to more than **400,000 deaths** in the U.S. every year.

- Patient safety is a serious public health issue. Like obesity, motor vehicle crashes, and breast cancer, harms caused during care have significant mortality, morbidity, and quality-of-life implications, and adversely affect patients in every care setting.

- **Is healthcare as safe as it should be?**

James, John T. PhD A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care ; *Journal of Patient Safety* 9(3):p 122-128, September 2013. | *DOI:* 10.1097/PTS.0b013e3182948a69

Human Errors in Healthcare

What is an Error?

- An unintentional deviation from desired performance due to a mistake, oversight, misunderstanding, lack of awareness, lack of knowledge, miscommunication, lapse, or slip.
- Doing the wrong thing when meaning to do the right thing.

Errors in Healthcare

- Everyone experiences errors, even experienced, professional people.
- Healthcare professionals work in high-risk situations that increase the chance we will make an error.

Errors can lead to patient harm

Zero Harm – How Do We Get There?

Understanding **why** we make errors and how to **prevent** Errors

The Science of Safety

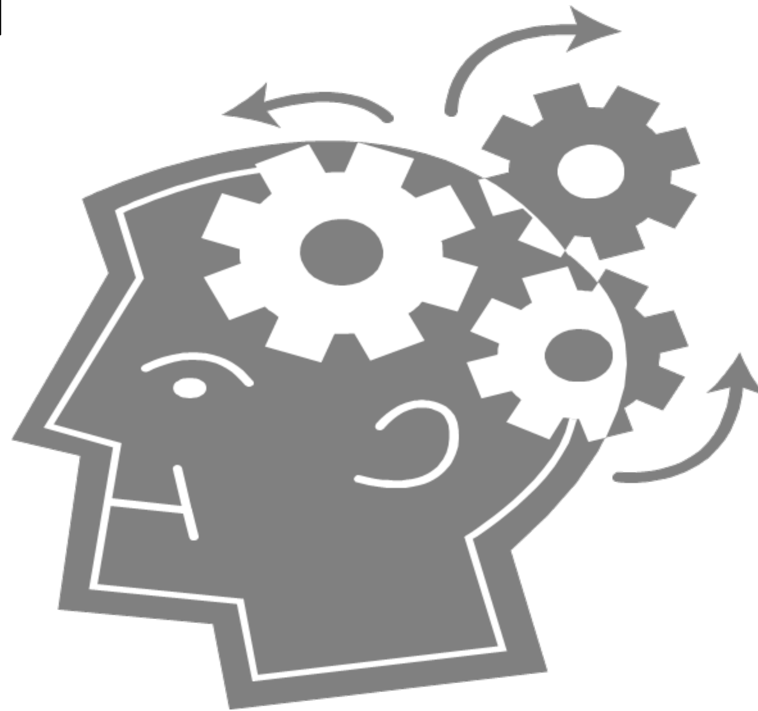
Let’s take a few minutes to understand how human performance affects the errors we make. We mentioned earlier that there is **“science”** behind how human beings perform.

Human error is predictable, and when we understand how mistakes are made, we can act to prevent and reduce the probability of human error.

Human Errors: Humans Work in Three Modes

Knowledge-Based Performance

"Figuring It Out Mode"



Rule-Based Performance

"If-Then Response Mode"

Skill-Based Performance**

"Auto-Pilot Mode"

****We are pretty reliable:** in skill-based performance, about 1 in 1,000 (0.1%) acts are performed in error.

Humans perform about 10,000 skill-based acts each day—that equals about 10 skill-based errors per day!

Skill-Based Performance

A well-developed skill pattern exists in your brain, developed through practice and repetition of an act.

We are doing tasks so routine and familiar that we don't even have to think about the task while we are doing it!

Skill-Based Performance

Examples of skill-based performance:

- Riding a bike; typing or writing by hand; making coffee; brushing teeth
- Putting milk in the fridge

Examples of skill-based errors?

- Putting the milk in the pantry instead of refrigerator
- Forgetting to add an attachment before sending an email!
- Not unmuting yourself to speak on zoom
- Programming the wrong medication rate in an IV pump
- Typing an order in a wrong patient's chart
- Diagnostic studies done on a wrong patient

Skill-Based Errors—How and Why They Occur

These conditions **increase the chance** you will experience an unintended error when performing **a familiar, routine task:**

- Working under time pressure
- Doing multiple things at the same time
- Distractions
- Interruptions
- Boredom
- Mental or physical exhaustion
- ***Just not paying attention***

Think about the conditions we face each day in healthcare—how many are on this list?

Rule-Based Performance

- Because individuals are responding to if-then decision sequences, misinterpretations of rules or deviations from prescribed procedures lead to mistakes.
- Errors involve deviating from an approved procedure, applying the wrong response to a work situation, or applying the correct procedure to the wrong situation.
- Examples of rule-based errors:

You may choose not to comply with a rule because you underestimate the consequences that would result.
Rule: Hand hygiene in and out of a patient's room. You choose not to follow the rule, underestimating the consequences.

Knowledge-Based Performance

- Knowledge-based performance relies on an individual's understanding of a task. Many errors result from flaws in that understanding.
- When forced to respond to novel circumstances, an individual will resort to what they know instead of surveying the situation and responding to facts on hand.

- Examples of knowledge-based errors:

An emergency situation occurs and there are new technology in place, then an individual relies on a previously known technique.

SAFETY Behaviors to Prevent Errors

Handoff Effectively

- Handoff happens when one individual who has responsibility for something, transfers that responsibility to another individual.

- If transfer or information is done incorrectly, an error could result.

- Accurate communication of information about a patient from one member of the health care team to another is a critical element of patient care and safety.

Handoff Effectively

- When communicating about an issue that needs resolution:
- **S**ituation: Who you are calling about, the immediate problem/concerns
- **B**ackground: Review pertinent information, environment, procedures
- **A**ssessment: Your assessment of the situation. I noticed that…
- **R**ecommendation: Your suggestion to or request to the other person

Handoff Effectively

- Effective discharge communication prevents errors with disease and medication management post – discharge

- A Mayo Clinic survey found that only about **42%** of discharged patients could name their diagnosis, **28%** could list all their medications, **37%** could state the purpose of their prescription drugs, and **14%** could identify the drugs' most common side effects.

Amgad N. Makaryus, MD ; Eli A. Friedman, MD Patients' Understanding of Their Treatment Plans and Diagnosis at Discharge; Mayo Clinic proceedings VOLUME 80, ISSUE 8, P991-994, AUGUST 2005 DOI:https://doi.org/10.4065/80.8.991

Speak-Up for Safety

If something doesn't seem right, then it's not right.

Having a questioning attitude helps prevent errors.

Question before confirming:
Questioning is an effective critical thinking tool.

Example:
A housekeeper questioning whether or not a patient is still on isolation. The sign they saw an hour ago is gone.
An engineer questioning wrong equipment delivered to a patient's room.

The Question:

- A high fall risk patient is on tele-sitter observation and a test has been ordered. Transport staff comes to pickup patient and notices the tele-sitter equipment in the room. He notices that the tele-sitter kept redirecting the patient. Should he take this patient to testing area without another staff member?

Confirm:

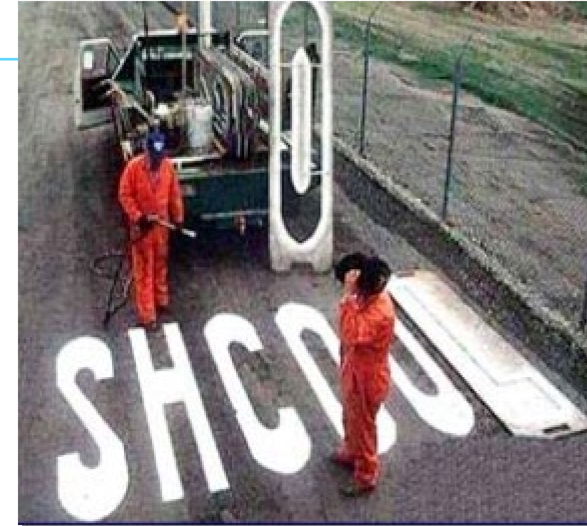
- He checks the policy, and it was not clear.
- Next, he asks the charge nurse who confirmed that a 1:1 sitter should accompany patient during transport.

Speak-Up for Safety

- **A (Ask a Question)**
- **R (Make a Request)**
- **C (Voice a Concern)**
- **C (Chain of Command)**

GOT Your Back

Peer checking



- This behavior is all about helping others.
- Watching each other's back and keep a colleague from doing an unsafe act
- Monitor the actions of other team members with the purpose of sharing the workload
- Identify slips and lapses and point them out

GOT Your Back

Peer coaching

- Encourage and praise others when they use safe and productive behaviors
- Discourage and give advice to others when they use unsafe and unproductive behaviors

Attention to Details

- Attention to detail is the ability to focus on all areas of a project or task, no matter how small.

- People with excellent attention to detail are thorough in reviewing their work.

Attention to Details

- STAR is a simple technique for preventing skill-based errors.
- Self-checking to avoid slips and lapses
- The best times to use STAR are when you are going from thought to action.

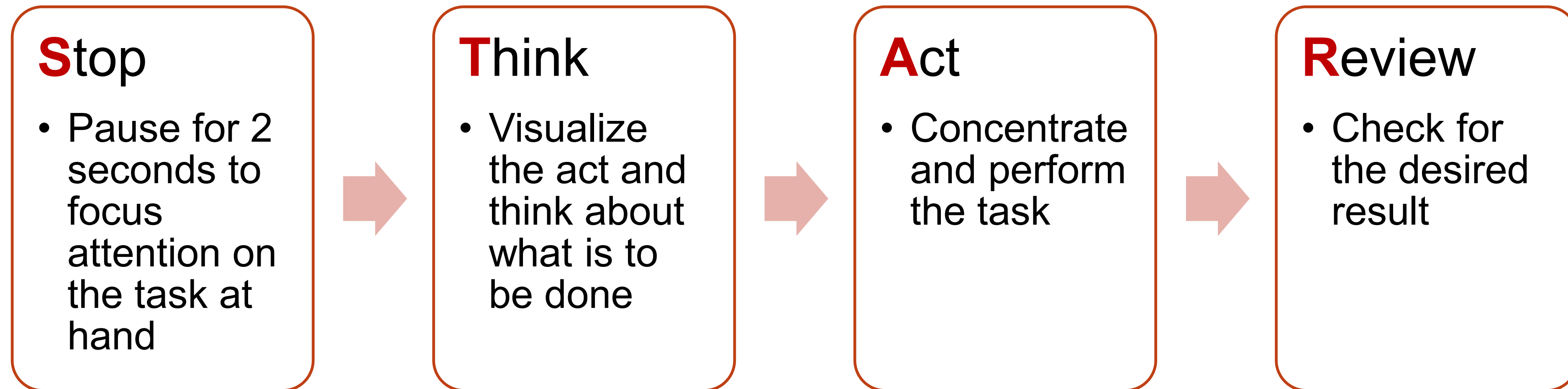
Attention to Details

STAR (Stop, Think, Act Review)

- STAR is a simple technique for preventing skill-based errors.
- Self-checking to avoid slips and lapses
- The best times to use STAR are when you are going from thought to action.

STAR

- **STAR** is a simple, 4 step tool for preventing skill-based errors by focusing attention to task.
- The best times to use **STAR** are when you are going from thought to action, such as **medication administration** or **sending an email with an attachment.**



Self-checking is the most effective way to avoids slips and lapses

STAR in Action

We already use **STAR** in many things we do.

The Power of the Pause

Now let's put self-checking using STAR to work!

Reading is a skill-based task. Most humans are so proficient at reading printed words that they cannot easily ignore them. In fact, it takes considerable attentional effort to ignore them.

On the next slide—we will see a grid with colored words

- *As a group, say the* ***color of the letters****, not the written word.*
- *We will read left-to-right, top-to-bottom.*
- *And because we all face a little time pressure from time-to-time, I will clap a beat to keep us together and in time.*
- *We'll start on the count of three…*

The Power of the Pause

YELLOW	GREEN	RED	ORANGE
BLACK	RED	YELLOW	PURPLE
RED	RED	GREEN	ORANGE
GREEN	BLUE	BLACK	YELLOW

Make Safety a Part of Your Day

- Think about situations at work where you can use **STAR**--Examples include ordering procedures, administering medications, or conducting business decisions.

- Pledge to use STAR during these situations.

References

- Agency for Healthcare Research and Quality (AHRQ). 2014. *Efforts To Improve Patient Safety Result in 1.3 Million Fewer Patient Harms: Interim Update on 2013 Annual Hospital-Acquired Condition Rate and Estimates of Cost Savings and Deaths Averted From 2010 to 2013.* Rockville, MD: Agency for Healthcare Research and Quality. AHRQ Publication No. 15-0011-EF. **http://www.psnet.ahrq.gov/resource.aspx?resourceID=28573**.

- AHRQ Quality and Safety Review System (QSRS). Content last reviewed September 2022. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/patient-safety/quality-measures/qsrs/index.html

- Institute of Medicine (US) Committee on Quality of Health Care in America. To Err is Human: Building a Safer Health System. Kohn LT, Corrigan JM, Donaldson MS, editors. Washington (DC): National Academies Press (US); 2000. PMID: 25077248.

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Thank you

- For any questions, please email ebonep@qlarant.com
- Please don't forget to complete the survey that will appear after you log off.
- Slides and recording will be emailed to you.